

# **WASHINGTON STATE 2001 HIV POLICY SUMMIT**

**NOVEMBER 11 – 13, 2001**

**Sun Mountain Lodge  
Twisp, Washington**

Report Prepared:

**August 2002**

HIV Policy Summit Planning Committee. Final Version, August 28, 2002.  
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## 2001 HIV POLICY SUMMIT OVERVIEW

In December 1995 persons and groups interested in and knowledgeable about the HIV/AIDS epidemic came together to assess then current prevention policies and future directions. This became the first Washington State HIV/AIDS Prevention Policy Summit. Summit delegates spent two and a half days discussing, assessing, and evaluating HIV prevention efforts throughout the State and developed recommendations to enhance such efforts. Their findings and recommendations were summarized in a report that resulted in an action plan, setting new direction for HIV prevention policies, programs, and practices in subsequent years. Among the delegates' recommendations was that the Summit should be reconvened in five years. The 2001 Summit was a direct result of that recommendation.

The 1995 HIV/AIDS Prevention Policy Summit occurred on the cusp of a new era in the care and treatment of HIV/AIDS. No longer was an HIV+ diagnosis a virtual death sentence. HIV could now be treated with sophisticated and often complex regimens involving the use of antiretrovirals. People with HIV were and continue to live longer lives. Although HIV prevention efforts remained critical to stopping the spread of the epidemic, increasing efforts were focused on care and treatment for HIV infected individuals. For a number of complex reasons, including turf issues and federal funding sources, prevention, and care and treatment services were often separate and distinct. This is changing. Public health officials, HIV/AIDS advocates, prevention and care service providers, consumers, funding agencies, and AIDS service organizations now advocate for and mandate a seamless continuum of prevention and care service delivery. Taking a proactive stance to this trend, 2001 Summit planners renamed the Summit Washington State HIV Policy Summit, directing delegates to focus on ways to obtain optimal integration of HIV prevention, and care and treatment services.

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## ACKNOWLEDGEMENTS

The HIV Policy Summit planning committee members would like to express our gratitude to the many delegates that made this report possible. Delegates comprised of people living with HIV/AIDS, health and social service providers, community advocates and activists, policy analysts, local and state government officials and educators from across the State contributed their time, knowledge, experiences, and practice wisdom. We are indebted to their commitment to enhance our State's system of prevention and care services and programs.

We value the energy and leadership of the facilitators, Rhonda Bierma, Nancy Hall, Dennis Torres, and Karl Swenson who guided discussion groups and kept delegates on task to accomplish the Summit's purpose within significant time constraints. We additionally value the work of our recorders, Debra Severson-Coffin, Alex Whitehouse, Kim Nguyen, and Lynn Johnik who made it possible to capture the important contributions delegates brought to the table.

We are indebted to MOM – Multi-Operations Monitor – Elaine Engle, who facilitated the work of planning committee members, delegates, group facilitators, and recorders by keeping us informed of room or schedule changes, supplied with paper and an array of colorful marking pens, note pads and post-its. She also moved among the different group discussions, observing and identifying potential problems early on so the planning committee could address them in a timely manner.

We want to express our appreciation also to the owners and staff at Sun Mountain Lodge, who contributed \$3,900 in-kind towards lodging and food and who provided excellent service, were exceptionally gracious, and consistently made us feel welcome.

We are grateful for the flexibility of the Summit evaluator, Mary Annese who agreed to step in during the final weeks of the planning process to carry out a commitment made by the NW AIDS Education and Training Center prior to her installment there as the Evaluation Manager.

Finally, we want to express our profound gratitude to Richard Stritmatter who contributed not only his wisdom but his wit and humor to planning and participating in the HIV Policy Summit and carrying out his assigned duties as the Sergeant-at-Arms, making sure that all delegates remained within their assigned Track. Richard died before this report was finalized but his untiring dedication in working towards improving the quality of prevention and care services for people living with HIV/AIDS will live on forever within the pages of this report.



## **EXECUTIVE SUMMARY**

In December 1995, the first Washington State HIV/AIDS Prevention Policy Summit convened to discuss, assess and evaluate HIV prevention efforts and develop recommendations to enhance these efforts. The final recommendation was to reconvene a Summit in five years. In 2000, a small planning group with representatives from the regional AIDS service networks (AIDSnets), the State Department of Health, the Governor's Advisory Committee on HIV/AIDS, HIV/AIDS community-based organizations, the Northwest AIDS Education and Training Center and consumers came together to plan the second Summit.

### **SUMMIT 2001 PURPOSE**

Recognizing the interconnectedness between prevention and care during the current era of the epidemic, the planners re-named the Summit the HIV Policy Summit. They identified the purpose of the Summit as enhancing current policies and practices to promote optimal integration of HIV prevention and care services by:

1. Promoting access to testing, treatment and adherence as a prevention strategy.
2. Facilitating rapid response to changes in risk behavior, co-morbidity (e.g., HCV, STDs, mental health, substance abuse) and demographics of the epidemic.
3. Taking advantage of new technologies in both behavioral and medical science.
4. Guiding allocation of funding to maximize the effective use of resources.

### **SUMMIT 2001 PROCESS**

The second Washington State HIV/AIDS Policy Summit took place in November 2001 at Sun Mountain Lodge in Twisp. As with the first Summit, delegates were invited in order to achieve a broad cross-section of stakeholders. Delegates were assigned to one of four tracks, each focusing on one of the four strategic areas of the Summit purpose statement. Prior to the Summit, each delegate received issue papers summarizing some of the current research and information related to track topics. Most of the Summit was devoted to meetings of the track groups, which, with facilitators and recorders, generated policy recommendations related to their issues. During the final plenary session group facilitators presented a combined total of 73 recommendations. Members of the planning committee met after the Summit to review and study the recommendations, resulting in the identification of six major themes for grouping recommendations and respective action steps.

### **SUMMIT 2001 RECOMMENDATIONS**

Following is a brief summary of recommendations and action steps Summit planning committee members identified from among those made by Summit delegates. These are presented in greater detail in the full report.

### **RECOMMENDATION #1**

*Theme:* HIV Testing and Counseling

*Action Step:* Increase the proportion of at-risk persons with knowledge of their HIV serostatus by improving access to quality testing and counseling services by trained providers in both prevention and care programs.

### **RECOMMENDATION #2**

*Theme:* Integration of Care and Prevention Services

*Action Step:* Increase integration and collaboration among HIV prevention, HIV care, and other related medical and social services founded in client-centered policies that ensure adequate funding, access to quality resources, and that are responsive to clients' changing needs.

### **RECOMMENDATION #3**

*Theme:* Stigma and Discrimination

*Action Step:* Increase action against stigma, ignorance and discrimination that hamper effective public health HIV prevention efforts, by having public health officials that provide exemplary leadership in combating discrimination, supporting healthy relationships among all people, and strengthening healthy community norms.

### **RECOMMENDATION #4**

*Theme:* Provider Education and Training

*Action Step:* Enhance effectiveness and integration of prevention and care services by cross training providers to increase knowledge about HIV community services, adherence, risk assessment, models, and cultural competency and in the use of technologies such chronic disease management tools and telemedicine.

### **RECOMMENDATION #5**

*Theme:* Effective Use of Emerging Technologies

*Action Step:* Increase the integration of emerging technologies into prevention and care services by creating a committee to identify, support implementation, and evaluate the use of new technologies, using data accurately and appropriately, identifying core competencies and best practices in achieving treatment adherence.

### **RECOMMENDATION #6**

*Theme:* HIV Prevention and Care Funding and Accountability

*Action Step:* Increase the accountability of public health leaders for efficient use of state and federal HIV prevention and care funds by improving transparency of and continued stakeholder involvement in planning, allocation and evaluation processes statewide, and introducing administrative efficiencies in distribution of public funds.

These recommendations and action steps were the result of rich discussion among Summit delegates of important policy issues related to prevention and care of HIV. They are

presented here with the hope by all that they will be enacted toward enhancing our efforts to stem the epidemic. Summit delegates strongly urged that such discussions continue.



## SECTION I

### FINAL RECOMMENDATIONS AND ACTION STEPS

These recommendations reflect and are founded in delegates' collective knowledge and experience across multiple and diverse disciplines, work activities, perspectives, and geographical boundaries. Recommendations are intended to inform legislative action and best practices. Many agencies, organizations and individuals in Washington State were represented at the 2001 HIV Policy Summit. In some way, all attendees bear some responsibility for carrying out recommendations and action steps resulting from the summit.

Summit Planners identified a variety of agencies and groups as having a role in achieving recommendations. These were then grouped to represent the following types of entities:

Government – Local/Regional/Tribal:	Local health jurisdictions and boards of health, regional AIDS service networks, tribes, other local government agencies
Government – State-Level:	Washington State Department of Health, State Board of Health, University of Washington
Community – Local/Regional:	Community-based organizations, AIDS service organizations, health and social service providers, local/regional planning groups, Ryan White Care Consortia
Community – State-Level:	State planning group; Governor's Advisory Council on HIV/AIDS; HIV/STD/Family Planning training organizations

Accomplishing action steps listed below will require effort, support and commitment from virtually all these groups and organizations. However, Summit Planners recognized that without some specific designation of primary and secondary responsibility, no concerted action might result. Thus, for most action steps "lead" group(s) and "support" organization(s) were identified. Designation of these roles in no way implies that other groups and organizations are not involved in carrying out the action steps. All agencies and organizations will need to support some action steps.

The following six pages fully document recommendations and action steps grouped by theme: HIV Counseling and Testing, Integration of Care and Prevention Services, Stigma and Discrimination, Provider Education and Training, Increased Integration of Emerging Technologies into Care and Prevention Services, and HIV Funding and Accountability. Each recommendation is followed by a series of action steps with numbers and letters that identify the source(s) of such by Summit track group (1, 2, 3, and 4). Thus, 1.p. represents recommendation p within track 1. Track recommendations, as expressed by delegates and recorded by track facilitators and recorders, are attached in appendices D through G. Many of the recommendations could have been included under multiple Action Steps. However, the Summit Planning Committee chose to include each recommendation only once – where it seemed the "best fit".

## **HIV Counseling and Testing**

**Recommendation: Increase the proportion of at-risk persons with knowledge of their HIV serostatus by:**

- Ensuring state laws and rules reflect current knowledge of HIV counseling and testing; promoting consistent quality services reflective of best practices, including use of peers and community leaders to assure cultural competence; and promoting the availability of services in related systems (e.g., criminal justice). (1.a., 1.b., 1.c., 1.e.)

*Lead: Department of Health/Board of Health*

*Support: Local Health Jurisdictions/Community-based Organizations*

- Improving disease control practices (e.g., case finding, partner notification, and peer recruitment of at-risk individuals) in or incorporating them into existing care and prevention programs. (2.k., 2.n.)

*Lead: AIDSnets /Local Health Jurisdictions*

*Support: Community-based Organizations*

- Promoting broad high-risk population awareness of the benefits of HIV counseling and testing. (1.f.)

*Lead: AIDSnets/Local Health Jurisdictions*

*Support: Community-based Organizations*

- Increasing access to new HIV testing technologies and reducing the length of time required for reporting of test results. (1.d., 2.o.)

*Lead: Department of Health*

*Support: AIDSnets*

- Training providers in risk assessment, especially sexual and drug-use history taking related to HIV risk. (1.h.)

*Lead: University of Washington Northwest AIDS Education and Training Center*

*Support: Local Health Jurisdictions*

## **Integration of Prevention and Care Services**

**Recommendation:** Increase integration and collaboration among HIV prevention, HIV care, and other related medical and social services in order to provide client-centered approaches by:

- Funding prevention services in care agencies serving significant numbers of persons infected with or at high risk for HIV. (1.p., 1.q., 2.g.)

*Lead: AIDSnets/Local Health Jurisdictions*

*Support: Care and Prevention Planning Groups and Consortia*

- Promoting client-centered harm reduction approaches and access to disease prevention materials (e.g., condoms, sterile injection paraphernalia) in HIV prevention and care services. (2.h., 2.i.)

*Lead: AIDSnets/Local Health Jurisdictions*

*Support: Community-based Organizations*

- Coordinating with other service systems and where possible, integrating services addressing co-factors, such as mental illness, chemical dependency, homelessness, and sexual abuse, of HIV disease. Specific measures could include: providing an up-to-date community resource directory; establishing a coalition of community service providers; and identifying a statewide group to develop recommendations to reduce barriers to system integration. (1.i., 3.e., 3.f., 3.g.)

*Lead: Care and Prevention Planning Groups and Consortia*

*Support: Governor's Advisory Council on HIV/AIDS*

- Establishing client-centered policies in HIV prevention, care and treatment; taking efforts to assist clients make knowledgeable decisions; and by recognizing client needs change over time, requiring periodic reassessment of prevention and care service needs. (3.r., 3.t., 3.u., 3.v.)

*Lead: Local Health Jurisdictions*

*Support: Community-based Organizations*

## **Stigma and Discrimination**

**Recommendation: Increase action against stigma, ignorance and discrimination that hamper effective public health HIV prevention and care efforts by:**

- Having public health officials provide leadership by setting examples of implementation and enforcement workplace policies and practices that combat discrimination, marginalization and exclusion. (2.s., 2.y., 3.k., 3.l.)

*Lead: Department of Health/Local Health Jurisdictions*

*Support: Community-based Organizations*

- Championing support for healthy relationships among all people, including those in same-sex relationships, by addressing homophobia, racism, domestic violence, power inequities, and sexual minorities needs in policy and practice. (2.x., 2.w., 3.m.)

*Lead: All*

- Providing accurate information to strengthen healthy community norms among at-risk populations to reduce risk behaviors, combat misconceptions about the real difficulties of living with HIV, and support self-disclosure of serostatus to providers and partners. (2.r., 2.t., 2.u., 2.v., 3.n.)

*Lead: Community-based Organizations*

*Support: Health and Social Service Providers*

## **Provider Education and Training**

### **Recommendation: Enhance effectiveness and integration of prevention and care services through provider training by:**

- Supporting local health jurisdictions and community-based organizations to provide cross training opportunities for mental health, health care, public health, corrections and addiction treatment professionals to increase provider knowledge about HIV community services. (1.g., 1.o., 2.d., 2.e., 2.f., 3.h., 3.i.)

*Lead: Care and Prevention Planning Groups and Consortia*  
*Support: Community-based Organizations*

- Widely disseminating information about the importance of treatment adherence. (1.m.)

*Lead: Department of Health*  
*Support: Health and Social Service Providers*

- Providing training on risk assessment, including sexual histories, client-centered approaches, cultural competency, and use of technologies such as computer-based tools. (3.b., 3.o., 3.s.)

*Lead: University of Washington Northwest AIDS Education and Training Center*  
*Support: HIV/STD/Family Planning training organizations*

- Providing training in technologies such as computer-based chronic disease management tools and telemedicine. (3.d., 3.j.)

*Lead: University of Washington Northwest AIDS Education and Training Center*  
*Support: HIV/STD/Family Planning training organizations*

## **Effective Use of Emerging Technologies**

### **Recommendation: Increase the integration of emerging technologies into prevention and care services by:**

- Creating a committee to identify new technologies, support their implementation, and evaluate their effectiveness. (2.l., 3.a., 3.c.)

*Lead: Department of Health*

*Support: Care and Prevention Planning Groups and Consortia*

- Using data accurately and appropriately to drive policy and program decisions, including modification of priorities and programs when data suggest new directions. (2.a., 2.b., 2.c., 2.p., 2.q.)

*Lead: Care and Prevention Planning Groups and Consortia*

*Support: All*

- Identifying the core competencies, including cultural competence, of best practices to achieve treatment adherence and providing technical assistance to develop effective adherence programs in communities (e.g., rural) with limited resources. (1.k., 1.l., 1.n.)

*Lead: Department of Health*

*Support: Health and Social Service Providers*

## **HIV Prevention/Care Funding and Accountability**

**Recommendation:** Increase the accountability of public health leaders for efficient use of state and federal HIV care/prevention funds by:

- Improving transparency of planning, allocation and evaluation processes statewide by the establishment of and adherence to standardized processes (e.g., standards of practice for intervention types, coordinator performance standards, prioritization and allocation processes, process for inviting Requests for Proposals.) (2.m., 4.a., 4.f.)

*Lead: Department of Health/AIDSnets*

*Support: All*

- Continuing and improving involvement of stakeholders and communities in all levels of the planning, delivery, and evaluation of publicly funded services and prevention/care systems integration. (1.j., 2.j., 3.p., 3.q., 4.b.)

*Lead: Care and Prevention Planning Groups and Consortia*

*Support: All*

- Introducing administrative efficiencies in distributing public funds such as synchronizing fiscal years to reduce administrative demand, allowing more flexibility for centralized funding within regions based on prevalence, developing cross-regional collaborations if appropriate, pooling some funds statewide to address special groups and issues, and identifying new funds from outdated mandates. (4.c., 4.d., 4.e., 4.g., 4.h.)

*Lead: Department of Health/AIDSnets*

*Support: Care and Prevention Planning Groups and Consortia*

- Advocating for and supporting the recommendations of the Summit should be led by the Department of Health and the Summit Planning Committee. (3.w., 3.x.)

*Lead: Department of Health/Summit Planning Committee*

*Support: All*



## SECTION II

### SUMMIT PROCESS EVALUATION

The Washington State HIV Policy Summit was held November 11<sup>th</sup> through 13<sup>th</sup> 2001 at Sun Mountain Lodge, Twisp, Washington. There were 73 Summit delegates, including Summit Planning Committee members in addition to support staff. Up to 97% of delegates completed and submitted evaluation forms that allowed them to assess overall and particular aspects of the Summit. This section is the result of those assessments, providing Planning Committee members important evaluative information about the Washington State HIV Policy Summit planning, content, and processes — information that will guide organizing efforts for future Summit events. All italicized text within this report section represents verbatim quotations.

### SUMMIT ORIGINS

In December 1995 persons and groups interested in and knowledgeable about the HIV/AIDS epidemic came together for the purpose of assessing then current prevention policies and future directions. This coming together became the first Washington State HIV/AIDS Prevention Policy Summit. Summit delegates spent two and a half days discussing, assessing, and evaluating HIV prevention efforts throughout the State and developing recommendations to enhance such efforts. Their findings and recommendations were summarized in a report that resulted in an action plan, setting new direction for HIV prevention policies, programs, and practices in subsequent years. Among the delegates' recommendations was that the Summit should be reconvened in five years. The 2001 Summit is a direct result of that recommendation.

The 1995 HIV/AIDS Prevention Policy Summit occurred on the cusp of a new era in the care and treatment of HIV/AIDS. No longer was an HIV+ diagnosis a virtual death sentence. HIV could now be treated with sophisticated and often complex regimens involving the use of antiretrovirals. People with HIV were living and continue to live longer lives. Although HIV prevention efforts remained critical to stopping the spread of the epidemic, increasing efforts were focused on care and treatment for HIV infected individuals. For a number of complex reasons, including turf issues and federal funding sources, prevention, and care and treatment services were often separate and distinct. This is changing as public health officials, HIV/AIDS advocates, prevention and care service providers, consumers, funding agencies, and AIDS service organizations advocate for and often mandate a seamless continuum of prevention and care service delivery. Taking a proactive stance to this trend, 2001 Summit planners decided to rename the Summit to the Washington State HIV Policy Summit, directing delegates to focus on ways to obtain optimal integration of HIV prevention, and care and treatment services.

## SUMMIT STRUCTURE AND PROCESSES

Summit 2001 structure and processes closely resembled those for the 1995 Summit. A small group of volunteers, some of whom were involved with the 1995 Summit, began planning the 2001 Summit about one year in advance of the actual date. This group became known as the Summit Planning Committee (SPC). Members represented AIDS service organizations, regional AIDS service networks, the Washington State Department of Health, the Governor's Advisory Council on HIV/AIDS, UW/NW AIDS Education and Training Center and the community.

Planning members met regularly in person, via e-mail and phone conferencing. Primary activities included funding development and selecting a site<sup>1</sup>, identifying and inviting delegates that would assure broad stakeholder representation; deciding relevant and meaningful policy issues, recruiting knowledgeable writers for these then reviewing and approving subject matter for general content and accuracy; creating the Summit agenda and design. Invitations and registration forms were later sent to delegates and approximately one week prior to the Summit delegates received copies of four policy issue papers intended to inform and guide Summit discussion and subsequent policy recommendations. Delegates were instructed to read the papers prior to their arrival at the Summit so that they could participate fully.

Once the Summit convened, SPC members were active participants and also took on such roles as recorder, host, and/or troubleshooter. This *great planning committee* with their active *commitment*, passion, and dedication to ensuring the overall quality of the Summit proceedings and well-being of delegates was recognized by delegates as contributing to the Summit's general success through *solid preparation* that generated *rich discussion in a safe environment*.

*Interesting conversation*, as well as *great dialogue* and the courageous *exchange of ideas* occurred over two days at Sun Mountain Lodge in Twisp, Washington, a remote yet beautiful facility ideally situated for accomplishing a lot of work away from the distractions and interruptions of daily life. Although some people found the location a bit too remote, a majority applauded the *beautiful setting and facilities* and appreciated being in a *place away to focus on discussion rather than close to home where you might be drawn away*.

*Respectful discussion* among *diverse, motivated, knowledgeable* delegates took place primarily in small groups titled "Tracks" based on the content of four policy issue papers. These were:

- Track 1: Promoting access to testing, treatment, and adherence as a prevention strategy.
- Track 2: Facilitating rapid response to changes in risk behavior, co-morbidity (i.e., HCV, STDs, mental health, substance abuse) and demographics of the epidemic.

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<sup>1</sup> See Appendices A and B for an explanation of funding revenue and expenditures and site selection criteria.

Track 3: Taking advantage of new technologies in both behavioral and medical science.

Track 4: Guiding allocation of funding to maximize the effective use of resources.

Planners, facilitators, recorders, and the evaluator arrived Saturday November 10<sup>th</sup>, a day prior to the Summit, in order to prepare for the work ahead. They met that afternoon to meet one another and clarify individual roles and responsibilities over the coming days. Evaluation forms were explained and distributed also. With tongue in cheek and a bit of humor in filling critical roles, SPC members selected a Multi-Operations Monitor, MOM for short—the acronym preceded the title, and a Sergeant-at-Arms. MOM provided facilitators and recorders with necessary supplies; shared important information on conflict resolution and handling challenging participants, consensus decision-making, and setting ground rules; and visually recorded Summit proceedings. In essence, MOM made sure that everyone's needs were being met and monitored all Summit activities. The Sergeant-at-Arms was charged with the responsibility of making sure that all delegates remained within their assigned Track.

Summit Day 1 — Sunday November 11, 2001

Delegates began arriving at Sun Mountain on Sunday November 11<sup>th</sup> where SPC members greeted them and other Summit support staff acted as registrars, handing out room assignments, keys, and Summit materials. Sundays are very busy days for Sun Mountain staff with large numbers of people checking out. The SPC was expecting as many as 100 people to arrive that day. By taking on the responsibility of checking in delegates, Summit support staff greatly reduced Sun Mountain staffs' work burden, streamlined registration for delegates, and maintained accurate Summit attendance records. A majority of delegates arrived by the end of the day.

Official Summit proceedings began later that evening with a welcome and overview by Kim Thorburn, Summit Planning Committee Chairperson, followed by a keynote address from the Washington State Secretary of Health, Mary Selecky. Secretary Selecky's words were passionate as she traced the history of HIV/AIDS work in Washington State—work accomplished by *warriors who became visionaries* and authored the 1988 Omnibus Act in an effort to *prevent people from dying*. Stating that *we've done good work in this State*, Secretary Selecky charged Summit delegates with the responsibility of determining how this work moves forward in an era of budget cuts, exclaiming that *you are warriors with a vision—you are the authors of tomorrow's words*.

After Secretary's Selecky's words were acknowledged with much applause, John Peppert from the Washington State Department of Health arose and introduced Sergeant-at-Arms Richard Stritmatter and his role as Track taskmaster. Sadly, Richard died shortly after the Summit but he will be remembered always as one of those long-time warriors and visionaries about whom Secretary Selecky spoke so passionately. Mr. Peppert also recognized another warrior, Brown McDonald, who after 11 years of service was leaving his role as the Region 6 AIDS Service Network Coordinator. Fellow delegates gave tribute to Brown, citing his

*integrity, perseverance and leadership, and his advocacy on behalf of people living with HIV/AIDS. Characterized, as both driven and organized Brown was truly very good at representing the voices of the community. For your resume, Brown!*

Immediately following the welcome, keynote address, introductions and acknowledgements, delegates proceeded to their respective Tracks where they spent the next full day and a half in intensive work sessions. The first evening generally was spent with introductions and establishing ground rules; only one group began intensive work around its respective issue topic. All four Tracks had a set of ground rules, however, it appears that Track facilitators either did not post or enforce these consistently because one weakness identified by a delegate was the *lack of respectful ground rules*.

#### Summit Day 2 — Monday November 12, 2001

Day two began in the morning and extended late into the evening. Delegates worked within their assigned Tracks all morning and afternoon. In the late afternoon they had the choice of attending a presentation of the HIV Prevention Study Committee's findings or to spend some free time relaxing and enjoying the surroundings. Almost two-thirds of all Summit participants (delegates, SPC, facilitators, recorders, evaluator) attended the presentation, which was facilitated by Maxine Hayes and Aaron Katz.

Aaron Katz is the Director of the Health Policy Analysis Program at the University of Washington, the program that assisted in the development and implementation of the HIV Prevention Study. The Study was initiated to take a hard look at some issues associated with the 1988 Omnibus Act. These included particularly the structure and function of the AIDS Service Networks. Study findings revealed some problem areas around Omnibus funding, HIV/AIDS education, and coordination between the WA State Department of Health and regional AIDS service networks, and HIV/AIDS prevention and care<sup>2</sup>. Although these were draft findings they were nonetheless presented at the Summit so as to contribute to the work of Summit delegates who were crafting recommended policies about related and overlapping issues.

Later that evening delegates regrouped in a large assembly area where they were broken into eight smaller groups for the purpose of exchanging ideas and thoughts about discussions taking place within their Track work groups. For some, *the breakout session Monday night with its smaller group discussions, which mixed participants from community, CBO's, public health and legislators* was one of the Summit's strengths. For example, one delegate stated *I loved Monday night— when we talked in small groups. I learned so much and gained valuable perspective*. There were contrasting viewpoints, however, as expressed by one delegate who clearly felt that the Monday night activity *wasn't useful*.

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<sup>2</sup> The WA State Department of Health has since issued The Health Policy Analysis Program's final report in which these issues are presented in greater depth.

## Summit Day 3 — November 13, 2001

On day three delegates concluded their work and finalized their policy recommendations. Facilitators or other representatives from each Track presented their group's recommendations to the full Summit and thanked everyone in their respective groups for their dedication and hard work.

Discussion then turned to challenges posed by the proposed cuts to state HIV/AIDS funding, potentially preventing advancement of the Summit's policy recommendations. After discussion and general consensus about the need to communicate this concern, the Summit concluded with a promise made by the Summit Planning Committee: they would send a letter on behalf of and naming all Summit delegates and other participants to Governor Gary Locke opposing proposed funding cuts. They further agreed that copies of this report would be sent to all. Lunches were distributed and evaluation forms gathered prior to delegates' departures. Summit Planning Committee members, facilitators, recorders, and the evaluator then spent time debriefing the overall Summit before they too departed.

## PROCESS EVALUATION METHODOLOGY

### Data Collection

Several data sources were used to assess the overall Summit and the small workgroups. These included:

- Overall Evaluation Instrument
- Track-specific Evaluation Instrument
- Recorders' Notes
- Individual Track Chart Notes
- Facilitator and Recorder Debrief Sheets
- Evaluator's Journal Notes and Observations

Overall Summit evaluation findings were premised on data collected from the Overall Evaluation Instrument on which space was provided for delegates to record their observations about and experiences at the Summit in general. This form was distributed by MOM at the end of day two and collected prior to delegates' departure on day three.

It was a 5-part form. Part one comprised 20 evaluative statements separated into 6 categories: Pre-summit, Summit, Process, Participant Representation, Environment, and Overview. Delegates were asked to rate each statement based on a continuous rating scale of 1 through 7, where 1 equaled disagree strongly and 7 equaled agree strongly. Parts two and three used the same rating scale<sup>3</sup> and asked delegates to rate large group facilitation and overall quality of Issue Papers, Accommodations, and Summit. Part 4 was designed to collect delegates' demographic information. Finally, part 5 provided space for delegates to

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<sup>3</sup> Same rating scale of 1 through 7 was used. However, the ratings were applied to qualities where 1 equaled low and 7 equaled high.

write personal commitments they would make in their day-to-day work as a result of their participation at the Summit. They also were asked to identify Summit strengths and weaknesses, whether or not it should be reconvened and if so, in how many years and ways it could be improved. Ninety-seven percent of delegates completed this evaluation form.

The Track-specific Evaluation Instrument was particular to delegates' participation in one of four track sessions. Track facilitators distributed these and they too were collected prior to delegates' departure on the final day. On this form, delegates were asked to evaluate track content, process, and facilitator qualities, using the same continuous rating scale of 1 through 7 described above. Supplementary data was obtained from recorder and track chart notes.

In addition to delegate evaluations, the Summit evaluator also asked track facilitators and recorders to complete a Debrief Sheet at the end of days two and three. Debrief sheets were designed to elicit information about the physical setting, levels of group participation, what went well, recommended changes, and emerging themes. Each of four track facilitators and/or recorders completed and submitted Debrief Sheets to the Summit evaluator. Information recorded in the evaluator's journal also contributed to evaluation findings.

### Data Analysis and Reporting

Numeric data were compiled and analyzed using standard statistical data analysis methods while textual data were coded and analyzed using standard qualitative data analysis methods. All data was treated as meaningful, that is no data was eliminated. All scores that appear in this report are mean scores unless otherwise noted. The highest possible mean score is 7.0 with a lowest possible mean score of 1.0 (see Appendix C for a list of mean scores and standard deviations).

## PROCESS EVALUATION FINDINGS

Evaluation findings indicated that the Summit experienced overall success. Delegates provided generally high ratings across a broad range of content and process evaluative statements, and place, event, and facilitator qualities. There was a general feeling of accomplishment and high levels of appreciation expressed for the *diverse opinions*, *perspectives*, and *knowledge* brought to discussions by fellow delegates.

Delegates expressed concerns about three issues that were problematic throughout the Summit and that emerged as a significant evaluation finding. First, the Issue Papers intended to provide background information for each of the tracks were rated relatively low in overall quality, were labeled *not useful* in some instances and set aside in other instances. Second, delegates consistently expressed experiencing inadequate time to obtain goals and/or to relax and enjoy the beauty of the natural surroundings. Third, some delegates expressed a degree of futility and frustration based on perceptions that some decisions were already made (particularly around pending budget cuts) and that there was a notable lack of *frontline workers* and *the public*. A fourth matter of concern emerged only upon compiling evaluation

data. That was, many delegates felt the Summit lacked broad representation, most notably from among *frontline workers*, and *the community*<sup>4</sup>.

### Delegate Participation

Summit attendance was by invitation in order to ensure broad and diverse representation of individuals particularly knowledgeable and experienced in HIV/AIDS prevention and/or care and treatment who also had a policy orientation. In July 2001 Summit Planning Committee members sent invitations to key stakeholder groups in Washington State, asking each to

<b>Figure 1. Demographic Profile of Delegates</b>	
<b>Race</b>	<b>Valid Percent *</b>
European American	80.0
African American	7.7
Asian/Pacific Islander	4.6
Biracial	4.6
Native American	3.1
<b>Hispanic/Latino</b>	
No	96.3
Yes	3.7
<b>Gender</b>	
Female	50.7
Male	49.3
Transgender	0.0
<b>Principal Type of Employment Setting</b>	
State and Local Public Health	42.2
AIDS Service/Community-based Organizations	31.3
Clinical Practice	9.4
State Government (non-health)	9.4
Schools/Universities	4.7
Corrections	3.1
<b>Principal Employment Geographical Location</b>	
Western Washington	79.5
Eastern Washington	20.5
<b>Principal Employment Description</b>	
Urban	16.9
Rural	12.3
Suburban	4.6
Reservation	1.5
Public	7.7
Mixed (urban/public/suburban)	56.9
* Percentages may be greater or less than 100% due to rounding.	

nominate up to four delegates to the Summit. Stakeholder groups receiving invitations included public, private, civic, religious, and governmental. Among these were the Washington State Department of Health, other state government agencies with a stake in HIV/AIDS, AIDSNet Regions, AIDS service and community-based organizations, faith communities, civil rights organizations, health insurance sector, public education and university sector, people infected and affected by HIV/AIDS, and media. Planners compiled a list of nominated delegates, determined gaps in representation, then identified and invited individuals that would fill those gaps as well as contribute to racial, ethnic, and cultural diversity. Figure 1 is a demographic profile of the Summit's delegates.

Although Summit planners sought to be as inclusive and representative as possible, Figure 1 indicates that individuals and groups significantly impacted by the epidemic (i.e., people of color), faith communities, people who live and work in Eastern Washington, rural communities, and individuals living or working on

reservations were under represented. In contrast, individuals from state government and local public health districts, divisions, and departments were over represented.

<sup>4</sup> The Summit Planning Committee purposefully chose to exclude frontline workers and the community based on the purpose of the Summit and the needed presence of people experienced in making policy level decisions.

Whereas tangible and external representation was less than ideal it is noteworthy that almost 50% of delegates applauded participant diversity as one of the Summit's major strengths. This was reflected in terms such as *broad perspectives, diversity of perspectives, variety of participants, variety of voices, such diverse and creative minds, diverse working backgrounds and variety of passion* and so forth. Consequently, it appears that Summit planners very successfully accomplished their goal of bringing together a group of people with diverse knowledge, skills, experiences, passions, and opinions. Nonetheless, the *lack of ethnic diversity* was an obvious Summit weakness and the reasons for it need to be addressed.

### Overall Quality

Delegates gave the highest ratings to the overall quality of their accommodations and the environment in general. Meeting rooms were comfortable. Lodging was highly satisfactory and there was strong agreement that special needs (i.e., dietary, access) were met. Similarly high ratings were assigned to the overall quality of the Summit and especially to processes that made delegates feel that their voices were heard with respect and that they had the opportunity to fully participate. Additionally, delegates strongly agreed that work started and ended on time.

Diversity of participant representation and large group facilitation received the second highest scores. Delegates more than agreed that there was a broad range of viewpoints and opinions expressed and heard. There was less agreement, however, that a broad range of diverse populations was present at the Summit, notably people of color and community people. The large group facilitator received mean scores of 5.82 and 5.77 for being responsive to questions and using culturally appropriate language but received lower scores for skill (5.62) and clarity (5.45).

Overall quality of Issue Papers received the lowest ratings with delegates reservedly neutral regarding the level of writing as appropriate to a diverse and broad audience. Other areas receiving low mean scores were related to time— inadequate time prior to the Summit to study the four Issue Papers and insufficient time to respond to each track's work (i.e., the large group sessions) and to accomplish overall goals. Notwithstanding, delegates more than agreed that they came to the Summit prepared to participate and that they had a clear understanding of their roles. They also felt that the Summit was generally a good forum for bringing together leaders in HIV prevention and care to discuss current, critical, and controversial public policy issues and for developing recommendations to address these. In fact, 95.2% of delegates indicated that the Summit should be reconvened. Recommendations for when the Summit should reconvene were distributed primarily across two years (30.5%), three years (27.1%), and five years (32.2%) with a mean of 3.24 years and a median of 3.00 years.

### Individual Tracks

The four Issue Papers constituted the four main conference tracks in which delegates either chose or were assigned to participate based on interest, knowledge, experience, and a need for balanced representation within tracks. Delegates were locked into their chosen or

assigned track for the duration of the Summit in order to facilitate continuity in workflow, thereby achieving the highest possible quality of work within a limited time frame. Tracks were evaluated individually on content, process, and facilitator qualities.

**Track 1: How can access to testing, treatment and adherence be promoted as prevention strategies?**

Facilitator:	Rhonda Bierma	Recorder:	Debra Severson-Coffin
Participants: Beth Anderson, Federico Cruz-Uribe, Douglas Larson, Aaliyah Messiah, Debra Nelson, Howard Russell, Judy Stone, Quinten Welch, Enric Morello, Linda Lake, Judith Billings, Aaron Katz, Scott Lindquist, Tracy Mikesell, John Peppert, Don Sloma, Fredrick Swanson, Adimika Meadows, Kelly Scott			

**Ground Rules**

Respect \_ Non-judgmental \_ Participation \_ Honesty \_ Don't Personalize \_ No Interrupting \_ No Side Bar Conversations \_ Be Succinct \_ Recognize the Common Mission \_ No "Sacred Cows" \_ Be Comfortable (Take Care of Yourself) \_ Articulate and Speak Loudly \_ Don't Beat a Dead Horse \_ No Wrong Perspectives \_ Some Things Are Facts \_ Let Quiet Voices Be Heard \_ Agree to Disagree (Quietly ? Respectfully) \_ Record All Voices

The Track 1 Issue Paper was a total of 13 pages. The author presented background information generally relevant to the topic, identified a series of barriers to accessing testing, treatment, and adherence programs, and discussed secondary prevention interventions and services. The paper concluded with a summary of barriers, considerations for future HIV prevention initiatives, and a set of six discussion questions that guided track discussions and the framework for developing policy recommendations. An extensive bibliography was included. The discussion questions were:

- How can RCW laws and WACs be modified to promote HIV counseling and testing for people at high risk?
- How can existing HIV counseling and testing programs be modified to overcome barriers to HIV testing?
- How can clients at highest risk that are identified through HIV counseling and testing programs be referred into additional effective interventions? Which interventions should be piloted first and who should provide those interventions?
- Which new case finding, partner management and clinical service models should be piloted?
- How should information about effective components of Adherence Programs be disseminated?
- How can collaborations between providers of public health services, AIDS services, medical care, mental health, substance abuse treatment, other community services, and evaluation services, be promoted for better integration of prevention and care?

Track 1 was comprised of 19 delegates. Approximately 90% completed and submitted track evaluation forms. The facilitator and recorder submitted track chart notes, completed debrief sheets, and a typed copy of recorder notes. Overall mean scores were:

Content:	4.00
Process:	5.84
Facilitator Qualities:	5.78

According to the facilitator and recorder, delegates seemed *very interested and focused* and *everyone participated at varying levels*. However, participation apparently was uneven the first day with a *handful of people doing most of the talking* while some delegates *spoke only once or twice*. More even participation was achieved the following day by working in smaller groups gathered at round tables where discussions were more focused in the process of narrowing recommendations. Overall, 94% of delegates agreed to strongly agreed they had the opportunity to participate fully.

Although delegates generally agreed that discussions were content focused and balanced, significantly fewer delegates agreed that there was sufficient time to accomplish their objectives with 41% indicating their group was unable to address all the discussion questions identified in the Issue Paper. The facilitator and recorder confirmed delegates' perceptions of inadequate discussion time, making similar notations on debrief sheets for both days. Additional commentary related to the Issue Paper was that it *was narrow and slanted rather than presenting options*.

Similar to overall Summit evaluation findings, processes received relatively high ratings for track participation. Almost 71% of delegates agreed to strongly agreed that their voices were heard with respect. Likewise, 76% felt that their opinions were captured and recorded accurately and 94% shared varying levels of agreement that track sessions began and ended on time. Since process skills are strongly associated with facilitator skills it is not surprising that the overall mean scores for process and facilitator quality are essentially the same.

Delegates were divided in their assessment of facilitator skills. Mean scores ranged between 4.06 for group facilitation skills and 5.41 the use of culturally appropriate language. Almost 56% of delegates felt that the facilitator was clear in presenting instructions and 59% gave positive ratings for responsiveness. Less than half the participants felt the facilitator was knowledgeable on Issue Paper content.

## Major Themes

Trust, especially the ability for people to trust agencies that provide testing and counseling services, emerged as a major theme throughout Track 1 discussions, primarily because trust is related to issues of confidentiality, informed consent, and culturally competent care and service. Protecting confidentiality and building trust could be obtained in part by assuring that agencies providing testing and counseling consistently and universally adhere to established guidelines. Meaningful discussion also ensued about whether or not testing and counseling activities needed to be as strongly connected as they currently are. A final

important theme to emerge was the importance of collaboration and partnership among agencies and stakeholders that provide a broad range of HIV/AIDS-related direct and indirect services. These themes are reflected in Track 1 policy recommendations located in Appendix D.

**Track 2: What are barriers to facilitating rapid response to changes in risk behavior, co-morbidity (HCV, TB, STD's, mental health, substance abuse) and demographics of the epidemic?**

Facilitator:	Nancy Hall	Recorder:	Alex Whitehouse
Participants: Dale Brieze, Karen Hartfield, Laurie Jenkins, Jimmy Minihan, Kris Nyrop, Jeffrey Schouten, Raleigh Watts, Dennis Worsham, Jo Hoffman, Maria Courogen, Barry Hilt, Paula Jones, Lenore Morrey, Toni Wright, Rickey Burchyett, Alex Whitehouse <sup>5</sup> , Dennis Klukan			

**Ground Rules**

Respect Each Other \_ Listen \_ Help Thy Neighbor \_ Confidentiality/Attribution \_ No Interrupting  
 \_ Speak to be Heard Not to Intimidate \_ Dead Horse Rule – Acknowledge the Body \_ Don't Dominate Discussion \_ Goal of Full Consensus \_ Full Consensus Modified to Ensure Representation of Minority Opinion(s)

The Track 2 Issue Paper was a total of 41 pages with more than half of the content dedicated to a very extensive bibliography and identification of additional resources. The author presented background information on a series of related topics with respective research conclusions, policy proposals for discussion, and discussion questions. However, the paper lacked consistency. For example, some sections contained research conclusions while others did not. Overall, the author set forth a total of 18 discussion questions in addition to another 18 policy proposals for discussion. Consequently, delegates synthesized and restated the questions as follow:

- What are the barriers to the effective use of surveillance or other data of co-morbid conditions as indicators of changing risk for HIV transmission?
- Are there 'best practices' or other models that are effective in their approaches to co-morbid conditions as a means to diminish acquisition and secondary transmission of HIV?
- How can 'best practice' models for cross-system collaboration (HIV, Mental Health, Substance Abuse, Corrections, TB, STD's) be promoted and funded?
- What is the evidence that a rapid response to changes in risk behavior is a desirable approach to prevention? Are there 'best practice' models out there?
- What role do stigma and discrimination play in the ability to respond to HIV/AIDS prevention and care in Washington State?

<sup>5</sup> The Track 2 recorder was unable to attend and Alex Whitehouse graciously took on the role of recorder in addition to his delegate role.

Track 2 was comprised of 17 delegates, 100% of who completed and submitted track evaluation forms. The facilitator and recorder submitted track chart notes, completed debrief sheets, and hand-written recorder notes. Overall mean scores were:

Content:	5.62
Process:	6.60
Facilitator Qualities:	6.51

According to the facilitator and recorder, delegates were an *incredible* group of individuals that were *very active* participants and *motivated enough for homework* conducted in small groups that met late into the evening first night or very early the following morning. Debrief sheets noted that *everyone got a chance to speak*. This was confirmed with 82% of the delegates strongly agreeing they had the opportunity to participate fully while the remainder expressed varying other levels of agreement.

All delegates agreed to strongly agreed that discussions were content focused and balanced. One hundred percent of delegates also agreed that they were able to address all the discussion questions; this result was interpreted to mean that delegates addressed all discussion questions as they restated them and not “as in the Issue Paper”, which is the terminology used on the evaluation form. Time was again problematic with delegates split in their agreement as to whether there was sufficient time to accomplish their objectives. Here too, the facilitator and recorder made notations on debrief sheets for both days attesting to the need for more time in general and specifically to facilitate small group processes within the track.

Similar to overall Summit evaluation findings, processes received relatively high ratings for track participation. All delegates agreed to strongly agreed that their voices were heard with respect. Likewise, 100% felt that their opinions were captured and recorded accurately and 100% agreed to strongly agreed that track sessions began and ended on time. Since group processes are strongly associated with facilitator skills it is not surprising that the overall mean scores for process and facilitator quality are essentially the same.

Delegates unanimously gave high ratings in facilitation skills. Mean scores ranged between 6.29 for being knowledgeable about Issue Paper content to 6.65 for being responsive to audience questions. Over 50% of delegates gave highest possible ratings to the facilitator’s use of culturally appropriate language and ability to provide clear direction.

### Major themes

Brainstorming as a means to addressing complex and difficult issues emerged as an important theme in Track 2. Delegates also sensed that defining emerging issues (such as changing patterns in risk behaviors) is a difficult task. Additional important themes that emerged from Track 2 discussion were that nothing is unpredictable, responses to the epidemic should be data-driven, stigma and discrimination are influential response factors must be acknowledged and addressed accordingly. These themes are reflected in Track 2 Policy Recommendations located in Appendix E.

**Track 3: How can new technologies in both medical and behavioral science be taken advantage of for primary and secondary prevention?**

Facilitator:	Dennis Torres	Recorder:	Kim Nguyen
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Participants: Wanda Hargrove, Brown McDonald, Richard Stritmatter, Paul Chen, David Richart, Stephen Dorn, Jack Jourden, Brad Rotor, John Wiesman, Wendy Doescher, Louis Cox, Janet Charles, Anne Meegan, Kim Thorburn, Muril Demory, Mary Saffold

## Ground Rules

Full Participation by All \_ Everybody on Time \_ Free to Invoke Hand Rule \_ Opinions are  
Opinions: No Rights No Wrongs \_ Modified Consensus \_ All Participants are Equal \_ Respect

The Track 3 Issue Paper was a total of 11 pages and was overly similar to the Issue Paper for Track 1 and even included an identical bibliography. The author presented background information and research conclusions relevant to the topic. Issue focus was almost entirely on technologies related to testing and counseling with only a couple paragraphs on the relationship between new technologies and treatment. The paper concluded with a list of four considerations for future HIV prevention initiatives and five discussion questions. These were:

- How can rapid testing, oral fluid testing and urine testing be more broadly implemented to improve acceptability of HIV counseling and testing among clients at highest risk?
- How can CLIA regulations be changed to open up the possibility of self-testing for HIV?
- What new programs and referral systems should be developed to implement effective group counseling interventions?
- How can ACASI risk assessment, interactive computer counseling and expanded telemedicine be integrated into existing testing and treatment programs?
- How should HAPDEU adherence program recommendations be implemented?

Track 3 was comprised of 16 delegates, 100% of who completed and submitted track evaluation forms. The facilitator and recorder submitted track chart notes, completed debrief sheets, and typed copies of recorder notes. Overall mean scores were:

Content:	4.90
Process:	6.63
Facilitator Qualities:	6.71

According to the facilitator and recorder, delegates were *very energized about the topics* under discussion and there was *over 90%* participation with people being *respectful* of one another and remaining *on track* while maintaining *interest and enthusiasm*. High levels of participation were also reflected evaluation ratings with 88% of delegates in strong agreement that they had the opportunity to participate fully.

While slightly more than half of the delegates agreed that discussions were content focused, 38% disagreed. In contrast, 86% of delegates agreed to strongly agreed that discussions were nicely balanced among Issue Paper findings, conclusions, and policy considerations. Time was less problematic for Track 3 delegates than for other delegates with 56% agreeing at varying levels that there was sufficient time to accomplish their objectives. However, the facilitator and recorder did note that more time was needed to *“hash out” some of the more controversial issues* and to *allow for people to break and get re-energized*.

Similar to overall Summit evaluation findings, processes received relatively high ratings for track participation. Almost all delegates agreed to strongly agreed that their voices were heard with respect. Likewise, 93% felt that their opinions were captured and recorded accurately and 100% agreed to strongly agreed that track sessions began and ended on time. Since group processes are strongly associated with facilitator skills it is not surprising that the overall mean scores for process and facilitator quality are essentially the same.

Delegates unanimously gave high ratings in facilitation skills. Mean scores ranged between 6.31 for being knowledgeable about Issue Paper content to 6.94 for group facilitation skills. Over 81% of delegates gave highest possible ratings to the facilitator’s use of culturally appropriate language and 100% gave high ratings for the facilitator’s ability to provide clear direction.

#### Major Themes

Probably the most important theme to emerge from Track 3 discussions centered on the need to get clinicians more involved in prevention and to increase their expertise in health education. Other major themes revolved around being clear on the differences between risk groups and risk behaviors and recognizing co-factors such as homelessness, mental health, and chemical dependency that put people at risk for acquiring HIV infection. These are reflected in Track 3 Policy Recommendations located in Appendix F.

#### **Track 4: How can allocation of prevention funds maximize the most effective use of current resources?**

Facilitator:	Karl Swenson	Recorder:	Lynn Johnigk
Participants: Peter Browning, Jesse Chipps, Jeannie Darnielle, Joel Hastings, Suzanne Hidde, James Holm, Dave Knutson, Jim Musslewhite, Anne Stuyvesant, Pat Malone, Frank Chaffee, Pam Colyar, Lindsey Frallic, Maxine Hayes, M. Ward Hinds, Larry Jecha, Phyllis Little, Shay Schual-Berke, Robert Free Galvan			

#### Ground Rules

Full Participation by All \_ Everybody on Time \_ Hand Rule – Free to Invoke \_ No Rights No Wrongs: Opinions \_ Modified Consensus \_ All Equal \_ Respect

The Track 4 Issue Paper was a total of 13 pages. The author provided information about funding sources, how and where allocations are made, and identified barriers to effective allocation. Although the author identified time constraints that prevented thorough discussion, the paper contained some information about allocation models and the principles that should drive allocation. There were 2 attachments: A copy of “RCW 70.24.400 Department to establish regional AIDS service networks – Funding – Lead counties – Regional plans – University of Washington, center for AIDS education” and a copy of allocation decisions made in October 1998 at an HIV Planning Retreat in Ellensburg, WA. There were no discussion questions. Consequently, delegates chose to make recommendations in 5 major topic areas related to allocation. These were:

- Goals and Objectives
- Accountability
- Decision-making
- Structural Change
- Maximizing Resources.

Track 4 was comprised of 19 delegates, 95% of whom completed and submitted track evaluation forms. The facilitator and recorder submitted track chart notes, completed debrief sheets, and hand-written copies of recorder notes. Overall mean scores were:

Content:	3.91
Process:	5.72
Facilitator Qualities:	5.37

According to the facilitator and recorder, delegates were *very knowledgeable* and *extremely interested in the topic* although the first day *interest waned* but delegates returned the second day with high levels of *interest and enthusiasm*. Overall there were high levels of participation with 89% of delegates expressing varying degrees of agreement that they had the opportunity to participate fully.

While a majority of the delegates (61%) agreed that discussions were content focused only half of the delegates agreed to strongly agreed that discussion time was evenly distributed across allocation methods, best practices, and principles identified in the Issue Paper. Time was most problematic for Track 4 delegates with 83% disagreeing at varying levels that there was sufficient time to accomplish their objectives. The facilitator and recorder affirmed this observation as they also noted that more time was needed *for discussion and decision making* especially on day two.

Similar to overall Summit evaluation findings, processes received relatively high ratings. Almost all delegates agreed to strongly agreed that their voices were heard with respect. Approximately 78% felt that their opinions were captured and recorded accurately and 82% agreed to strongly agreed that track sessions began and ended on time. Since group processes are strongly associated with facilitator skills it is not surprising that the overall mean scores for process and facilitator quality are so similar.

Delegates gave consistent ratings in facilitation skills. Mean scores ranged between 5.17 for clarity and 5.50 for the use of culturally appropriate language. Almost 84% of all delegates gave the facilitator high ratings for being knowledgeable about Issue Paper content while 72% and 77% gave high ratings for responsiveness and group facilitation skills, respectively.

## Major Themes

Two major themes emerged from Track 4 discussions. One was based on the need for improved and increased cross-disciplinary collaboration. The second was stated in the form of a question. How can we start over from scratch to evaluate what works best? This question is related to the current structure of the AIDS Services Networks and allocation methods. Debate ensued about the feasibility of tearing down existing structures and building new ones based on proven best practices. These themes are reflected in Track 4 Policy Recommendations located in Appendix G.

## Summit Strengths

There were a total of 108 strengths identified by 61 delegates. These were grouped into five categories: Participants, Knowledge Sharing, Location, Diversity, and Leadership. Figure 2 displays these categories and their related concepts.

**Figure 2. Summit Strengths**

Participants	Knowledge Sharing	Location	Diversity	Leadership
Knowledgeable	Voice thoughts	Remote	Perspectives	Planning
Passionate	Listen to other voices	Beautiful	People	Agenda
Great	Group discussions	Retreat	Work groups	Facilitation
Diverse	Integration care and prevention	Stay focused	Opinions	Presence of
Experiences of	Feedback	Excellent	Voices	Commitment
Motivated	Team work	Lovely		
Commitment	In safe environment	No distractions		
Energy	Best practices			
Passion	Exchange of ideas			
Courage	Challenge existing ideas			
Phenomenal	Valuable perspectives			
Intelligence	HIV Study findings			
Caring	Without prejudice			
Talent	Without judgement			

As Figure 2 demonstrates the majority of Summit strengths centered on the presence of intelligent and experienced participants engaged in knowledge sharing. Since this is exactly what the Summit was designed to accomplish this is a remarkable indicator of successful planning on behalf of the Summit Planning Committee.

## Summit Weaknesses

There were a total of 88 weaknesses identified by 56 participants. Weaknesses were primarily related to issues of time, quality of Issue Papers, participant representation, Summit content and processes, a sense of futility.

Delegates expressed a need for more **time** all around. They desired more time in their tracks to better accomplish objectives and give fair discussion to controversial issues that arose and were left unresolved. For at least one track that meant that some good ideas were not included in their final recommendations. Delegates also wanted more time for full Summit group discussions in order to learn more about and contribute to the ideas being generated and to have ownership over all the recommendations developed. Especially, as one delegate phrased it, *I had no role in contributing to the other groups' recommendations, yet my name will be on the report....* Delegates further expressed a need for more time to enjoy the surrounding countryside and to take breaks in order to renew their energy. Several delegates suggested increasing the time by at least ½ day and up to one full day.

**Issue Papers** received consistently low ratings as noted in the overall and track evaluation findings. Delegates' comments strengthened the observation that these papers did not meet Summit needs or expectations. They were characterized as *Seattle-centric, not succinct, weak and confusing*. Although one delegate noted that a specific Issue Paper was *well crafted*, this same delegate also noted that it *read like a finished product with minor issues to address* and it focused heavily on prevention rather than the integration of care and prevention.

**Participant representation** was problematic for some delegates who believed that there were not enough community people present and implied that they were excluded based on a misperception that they lacked the capacity to contribute fully. One delegate indicated that there were too many people present with an *advocate perspective* while another believed that the majority of those invited shared many views and lacked objectivity.

Identified weaknesses about **Summit content and processes** were far less than those identified in the above categories of time, Issue Papers, and participant representation. Nonetheless, delegates did note some concern over the lack of direction for their participation in the full Summit and track work groups. They also wanted more information about what occurred at the previous Summit in 1995 and the status of recommendations that came out of that Summit. An additional weakness was the strong focus on prevention rather than the integration of care and prevention as the Summit intended. Some delegates also expressed a need for better facilitation overall and a clearer picture of the value of the work they were doing.

A small number of delegates expressed a **sense of futility**, feeling like decisions had already been made around some of the issues under discussion. Particular concern was expressed that the Washington State Health Department would ignore recommendations as *it is locked into certain ways of being* and that it stifled creativity by setting the stage to *accept funding cuts rather than encouraging people to fight* against them.

## Conclusions

Evaluation findings indicate that the HIV Policy Summit enjoyed a high level of success. The Summit Planning Committee achieved its goal to generate thought provoking and meaningful discussion around difficult policy issues that would result in a set of well-crafted recommendations to share with elected leaders and key stakeholders. Resultant policy recommendations will strengthen continued efforts to prevent the spread of HIV and to provide quality care for people living with HIV/AIDS by directing effective integration of prevention and care services and programs founded in best practices and enhanced by new technologies. They provide a solid framework for proactively responding to rapid changes in the prevention, care and treatment of HIV.

## Summit Process Recommendations

Summit delegates and other participants contributed several recommendations for improving the quality of future summits. Most telling among these was that among Summit participants responding to a question about if and when the Summit should be reconvened, almost 94% wanted the Summit to reconvene. More than half of these wanted the Summit to reconvene between two and three years, however, 3 years was the mean time for reconvening the Summit. Recommendations for improving the next Summit included site location, duration, improved processes and quality of pre-summit materials.

### **Site Location:**

- Continue to use a location that removes people from their daily routines.

### **Summit Duration:**

- Increase the length of time to at least two full days.
- Factor in breaks and more time for large group interaction.

### **Improve Summit Processes:**

- Recruit skilled and experienced facilitators (or hire if necessary).
- Bring evaluator on board when planning meetings begin.
- Increase participant diversity especially from among racial/ethnic groups and community.
- Set general ground rules for the entire Summit.
- Exercise greater clarity about work to be done, expectations, purpose, consequences, and next steps.
- Use smaller and more groups to work on issues even if it means 2-3 groups discuss different aspects of the same paper.
- Focus topics.
- Facilitate greater integration of prevention and care throughout.

**Pre-summit Materials:**

- Identify critical policy issues more in advance; recruit writers earlier; set standards for paper submission (i.e., content, layout, length) to promote continuity; distribute papers earlier.



## **APPENDIX A**

### **2001 HIV POLICY SUMMIT BUDGET**

A work group comprised of Kim Thorburn and Jeff Schouten developed a preliminary budget in the winter of 2000/2001. This was used as a guide to plan fund raising for the Summit. Planning time and expenses were largely donated by members of the Planning Committee. Participants in the Summit would be expected to provide their own transportation to/from the event. Lifelong AIDS Alliance donated their services as fiscal agent for the event. The only planned expenses were 1) consultants to help write discussion papers, and 2) facility/accommodations for all participants and facilitators.

As the year progressed, other decisions were made that had an impact on the budget. A facility was selected, fewer consultants were used, and more people were invited to participate. In the end, the final budget was approximately 25% less than originally proposed. Responsibility for fund raising rested with the State Department of Health and regional AIDS service networks. A surprise donation was received from the AIDS Services and Prevention Coalition, which closed down its operation and contributed its fund balance to the Summit. The selected facility provided generous off-season price breaks and donated some of the amenities, valued at \$3,900.

#### **REVENUES**

ASAP Donation	\$ 1,956.60
Region 1 contribution	\$ 3,553.29
Region 2 contribution	\$ 3,553.29
Region 3 contribution	\$ 3,553.29
Region 4 contribution	\$ 5,329.93
Region 5 contribution	\$ 3,553.29
Region 6 contribution	\$ 3,553.29
<u>WA DOH contribution</u>	<u>\$ 5,329.93</u>
TOTAL	\$30,382.91

#### **EXPENDITURES**

Consultants*	\$ 1,500.00
Facility/accommodations**	\$28,697.63
<u>Other-1 Facilitator's travel</u>	<u>\$ 185.27</u>
TOTAL	\$30,382.90

\*Consultants retained were Freya Spielberg (2 papers) and Allan Blackman (1 paper).

\*\*All Facility/accommodation expenses were paid to Sun Mountain Lodge, Twisp, WA.



## **APPENDIX B**

### **CRITERIA FOR SITE SELECTION**

Between November 2000-February 2001 a work team comprised of Anne Stuyvesant and Alex Whitehouse spearheaded the location and facility selection process. Criteria used included many of the same characteristics identified in the first HIV Summit in 1995. Once the full Planning Committee ratified criteria, the work group conducted a formal Request For Proposal process. Ninety-two potential sites received the announcement, forty-one responded and among these, twenty-nine met most of our basic requirements. These were examined more closely and eight were selected for further consideration. The most promising candidates received a site visit. The Committee heard reports from the work group and made the final selection. Among considerations for the chosen site were:

- Ability to comfortably handle 90-95 participants and facilitators;
- Available 48-hours for the Summit itself, including from noon one day and ending noon two days later;
- Available the night before and evening after the Summit for planners, facilitators and note takers to meet;
- Available on selected dates in November-December 2001;
- Meals included with flexibility to handle participants' special dietary needs as required;
- Refreshments included throughout the Summit;
- Ability to handle approximately 95 single occupancy rooms with some flexibility for shared rooms;
- Must be handicap accessible in all facilities, pursuant to ADA;
- Must have a medical physician available on-call for emergencies;
- Conference area must include audio/visual equipment, sound amplification, flip charts and chalkboards;
- Preference for facility that is quiet, isolated and amenable to intensive and late night work;
- Preference for a facility centrally located and accessible for participants coming from throughout the state;
- Low cost but also meeting above criteria (with potential to provide discounts or in-kind donations for some of the expenses.)

Sun Mountain Lodge in Twisp, Washington provided the best possible retreat facility at the most reasonable cost, including giving generous off-season discounts and in-kind contributions. Feedback from almost all participants was favorable.



## APPENDIX C

### MEAN SCORES AND STANDARD DEVIATIONS FOR EVALUATIVE STATEMENTS

1. Please rate the following *evaluation* statements by writing in the right hand column the number that best corresponds with your level of agreement or disagreement. Thank you.

1 = Disagree Strongly

4 = Neutral

7 = Agree Strongly

Evaluation Statements	Mean	s.d.
<b>Pre-Summit:</b>		
The invitation letter clearly defined my role as participant.	5.51	1.31
There was adequate time prior to the Summit to study the four Issue Papers.	4.81	1.59
Level of writing for Issue Papers was appropriate to a diverse and broad audience.	4.49	1.44
I came to the Summit fully prepared to participate.	5.72	1.23
<b>Summit:</b>		
There was a good balance between large and small work group sessions.	5.62	1.16
Large group sessions provided sufficient time to respond to each track's work	4.66	1.44
We accomplished our overall goals in the large group discussions.	4.85	1.34
HIV care and prevention were equally represented.	5.22	1.70
<b>Process:</b>		
I felt like my voice was heard with respect.	6.21	1.18
I had the opportunity to fully participate.	6.34	.98
We started and ended on time.	6.25	.91
<b>Participant Representation:</b>		
A broad range of diverse populations were present at the Summit.	5.34	1.60
There was a good balance of representatives from the public sector, private sector, and community groups.	5.52	1.41
There was a broad range of viewpoints and opinions expressed and heard.	5.76	1.28
<b>Environment:</b>		
Meetings rooms were comfortable.	6.21	1.21
I was satisfied with my lodging.	6.77	.61
My special needs were met.	6.36	1.24
<b>Overview:</b>		
The Summit is a good forum for discussing current, critical, and controversial public policy issues.	5.94	1.05
The Summit is a good forum for bringing together leaders in HIV prevention and care.	6.23	.95
The Summit is a good forum for developing HIV prevention and care policy recommendations.	5.64	1.31

2. Please rate **large group facilitation** on the following qualities by circling the number that best represents your opinion.

1 = Low      4 = Moderate      7 = High

Large Group Facilitation	Mean	s.d.
Group Facilitation Skills	5.67	1.11
Culturally Appropriate Use of Language	5.77	1.20
Responsive to Questions	5.82	1.23
Clarity in Presenting Instructions	5.45	1.25

3. PLEASE RATE THE FOLLOWING STATEMENTS BY CIRCLING THE NUMBER THAT BEST REPRESENTS YOUR OPINION.

1 = Low      4 = Moderate      7 = High

Overall Quality	Mean	s.d.
Overall quality of <i>Issue Papers</i> :	4.58	1.40
Overall quality of accommodations:	6.81	.52
Overall quality of Summit:	6.01	.96

## APPENDIX D

### TRACK 1 POLICY RECOMMENDATIONS

- a. Increase access to testing by making alterations in the WAC's and RCW's to reflect current knowledge about counseling and testing settings, content and delivery.
- b. Use peers and community leaders (including HIV+ individuals) to assure access to culturally competent testing and counseling in a variety of venues.
- c. Promote consistent content for counseling and quality standards for testing in all settings through provider education and promotion of best practices; allow flexibility in the mode of counseling communication (written, face-to-face, video).
- d. Increase access to new testing technologies, including rapid tests and alternatives to venipuncture testing both at State Lab and private laboratories; decrease turn around times at the State Lab.
- e. Improve quality of and access to counseling and testing in the criminal justice system.
- f. Promote broad community "high risk" population awareness of the benefits of counseling and testing through the media and other means.
- g. Increase provider knowledge of HIV community services available to their clients.
- h. Train providers in sexual history taking especially related to HIV risk.
- i. Increase partnership among public health providers, community clinics, non-traditional organizations (e.g., churches, civic organizations) to foster effective intervention strategies. Encourage funding agencies to track referrals and collaborative partnership activities.
- j. Promote flexibility with job qualifications and create a job clearinghouse (or statewide "posting board) for HIV service positions where community members (including individuals with HIV) can access job opportunities. The purpose is to recruit and retain competent staff as well as create job opportunities for people with HIV.
- k. Identify core competencies of effective adherence interventions using the University of Washington's HIV AIDS Project Development Unit's (HAPDEU's) 1-year study (1999 – 2000) on adherence, and other relevant studies.
- l. Use care and prevention planning groups (i.e., State Planning Group, regional planning groups, and local care consortia) to identify rural communities that may need technical assistance to provide effective adherence programs with limited resources.

- m. Use the WA State Responds monthly publication, Internet and Websites to disseminate information about best practices, the importance of adherence, and articles that emphasize quality of life issues.
- n. Use cultural competency standards to assure that adherence materials are appropriate for targeted audiences, including racial, ethnic, gender, sexual orientation and people with multiple diagnoses (e.g., mental health and CD status).
- o. Improve integration of prevention and care services by providing increased opportunities for cross training of mental health, health care, public health, and addiction treatment providers.
- p. Public health should fund programs that promote integration of prevention services within care providers serving significant numbers of persons with HIV and those at risk for HIV.
- q. Public health should fund prevention services within HIV care agencies as a method of modeling integration of prevention and care services.

## **APPENDIX E**

### **TRACK 2 POLICY RECOMMENDATIONS**

#### **QUESTION 1: WHAT ARE THE BARRIERS TO THE EFFECTIVE USE OF SURVEILLANCE OR OTHER DATA OF CO-MORBID CONDITIONS AS INDICATORS OF CHANGING RISK FOR HIV TRANSMISSION?**

We acknowledge that data are limited and there is a need for more. However, in this era of decreasing resources, the sources we currently have are likely to be the only ones we'll have to work with. Therefore:

Recommendations:

- a. Data should be the primary driver for all policy and program decisions (care/prevention) in WA. Examples of currently available data: HIV/AIDS case surveillance, epidemiological and behavioral studies, and evaluation studies.
- b. Users must know how to interpret and apply the data, as well as understand their limitations. Planning groups should actively solicit analysis and interpretation of available data from appropriate experts before making policy, program and priority decisions.
- c. When available data suggest new directions, planning groups and program monitors should modify their priorities and programs based on emerging needs.

#### **Original Question 2: Are there 'best practices' or other models that are effective in their approaches to co-morbid conditions as a means to diminish acquisition and secondary transmission of HIV?**

#### **Restated question 2: How can 'best practice' models for cross-system collaboration (HIV, Mental Health, Substance Abuse, Corrections, TB, STD's) be promoted and funded?**

People at risk or infected are now more difficult to identify, reach and serve (care/prevention) due to co-morbidities (especially Mental Health, Substance Abuse and involvement in corrections).

Recommendations:

- d. HIV funders provide opportunities for cross training in mental health, substance abuse, STD's, Hepatitis and corrections.
- e. Intent of cross-training is to improve effective services to at risk populations.

Co-morbid systems and workers need cross training on HIV prevention and care, effective interventions, client assessments and harm reduction.

Recommendations:

- f. Regional AIDSnets work with local health jurisdictions (LHJs), agencies and community-based organizations (CBOs) to provide appropriate and consistent cross training with appropriate mental health, substance abuse, STD and corrections staff. (For small jurisdictions, regional or state staff may provide a regional training.)
- g. Encourage, as per Omnibus legislation, collaboration between care/prevention services and mental health, substance abuse, STD and corrections programs.

There are areas where ‘best practice’ should be maintained or strengthened.

Recommendations:

- h. Access to clean injecting paraphernalia should be basic to prevention/care of practicing injecting drug users (IDUs), to prevent the spread of blood borne pathogens (BBPs). (Good public health practice)
- i. Harm reduction (strategies and interventions that are client-centered and support the client in their process, ranging from abstinence to prophylaxis) approaches should be incorporated in all care/prevention strategies to reduce transmission of HIV, STDs and BBPs. (Good public health practice)
- j. Continue and improve involvement of all levels of communities in the care/prevention process, including planning, implementation and evaluation.
- k. Improve disease control practices including: disease investigation, partner notification, peer recruitment of at risk individuals.

Develop standards for emerging ‘best practices.’

Recommendations:

- l. Implement and evaluate emerging interventions to determine level of efficacy. Example: Prevention case management.
- m. Establish standard of practice for intervention types through CDC intervention plan review process, with adaptation for varying settings, physical locations and cultural needs.

**Question 3: What is the evidence that a rapid response to changes in risk behavior is a desirable approach to prevention? Are there ‘best practice’ models out there?**

There are examples of the efficacy of a timely response, both in changing behaviors and increase in case finding (Vancouver B.C. needle exchange, rapid testing, Oasis Project). A major finding is data showing lowering an individual’s viral load may lower transmission. Use of LSEA (Lower sensitivity ELIZA assay) should allow for cost effective use of resources for partner notification because it would indicate the time frame of HIV infection and aid in prioritizing notification efforts.

Recommendations:

- n. These approaches, including testing, partner notification, case finding, etc. should be incorporated into existing care and prevention programs.

- o. Resources should be directed to fund needle-less rapid HIV testing to identify high-risk populations.
- p. Sero-surveys should be considered to confirm a sudden change of incidence in HIV infection.
- q. In the event of a sudden change, experts should be directed to review the behavioral and environmental factors and recommend responses.

**Question 4: What role do stigma and discrimination play in the ability to respond to HIV/AIDS prevention and care in Washington State?**

General Observations:

- You can't talk about stigma without talking about culture. Understanding stigma requires a high level of cultural competency and sensitivity
- Multiple stigmas impact this epidemic:
  1. Stigma about being HIV+
  2. Stigma about behaviors that result in HIV infection
  3. Stigma about groups: gay; people of color; drug user, mentally ill, etc.
- Sometimes public health should fight stigmatization (e.g. reducing health disparities); sometimes public health should encourage stigmatization (e.g. smokers)
- Discrimination can result when stigmatization becomes law, policy or social norm. Discrimination related to HIV status or risk group is unacceptable
- International lessons about fighting stigma may be useful in Washington. Example: public health leaders speaking out against stigma
- Fighting stigma and discrimination is one thing that motivates activists, public health staff and donors to remain involved in the epidemic
- Stigma plays out differently in urban vs. rural areas.

*Stigma about having HIV.*

Recommendations:

- r. Public Health and CBOs should publicize to at-risk populations how hard it is to live with HIV.
- s. Diversify health care work force so the care system feels more welcoming to all HIV+ people.
- t. Review the interaction of care and prevention to determine whether care services are a disincentive to prevention (Is there an 'entitlement' incentive?).

*Stigma about behaviors that result in HIV transmission*

Recommendations:

- u. Efforts to change community norms about unprotected anal intercourse (UAI) with multiple partners and paraphernalia sharing. Public health and at-risk communities

should work together to promote HIV+ persons retaining or practicing responsible behaviors.

- v. Public health and CBOs should work to influence the community norms about the negative aspects of contracting HIV. “Fear” or “truth” messages about the realities of HIV may be useful and should also recommend positive actions.

### *Stigma related to groups*

Public health should show leadership in fighting stigma by promoting the conditions that lead to healthy relationships and healthy living conditions. Specifically:

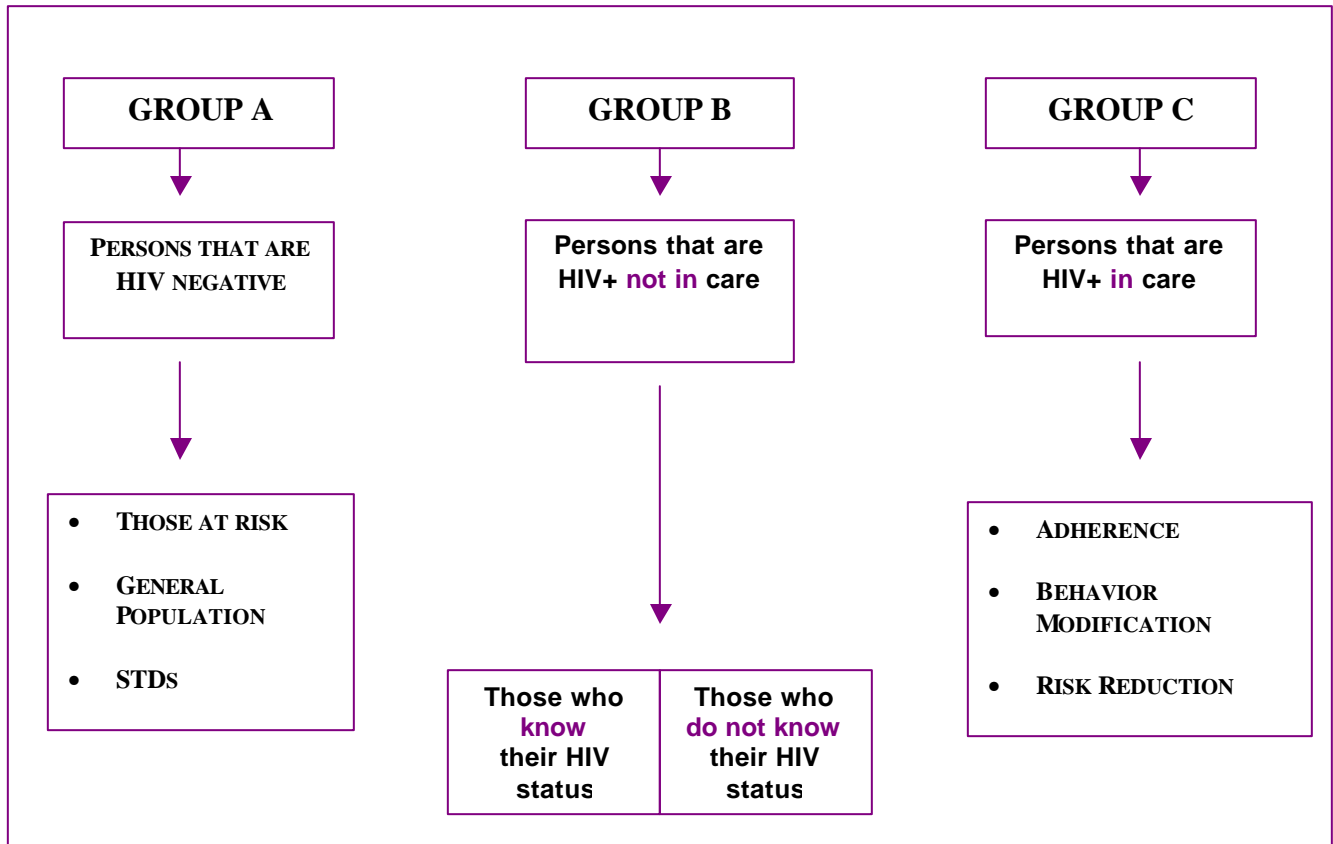
#### Recommendations:

- w. Public health should support healthy, responsible and legally recognized same sex relationship.
- x. Public health should support healthy and responsible relationships by working to prevent domestic violence and other inequities/power issues (empower women and healthy gay and straight intimate relationships)
- y. Public health should show leadership in fighting racial health disparities in HIV.

## APPENDIX F

### TRACK 3 POLICY RECOMMENDATIONS

Recommendations were discussed within the following conceptual framework:



1. Monitor the emergence of new technologies.

Specifically: a. Create a committee to look at new technologies on an ongoing basis and to make recommendations.

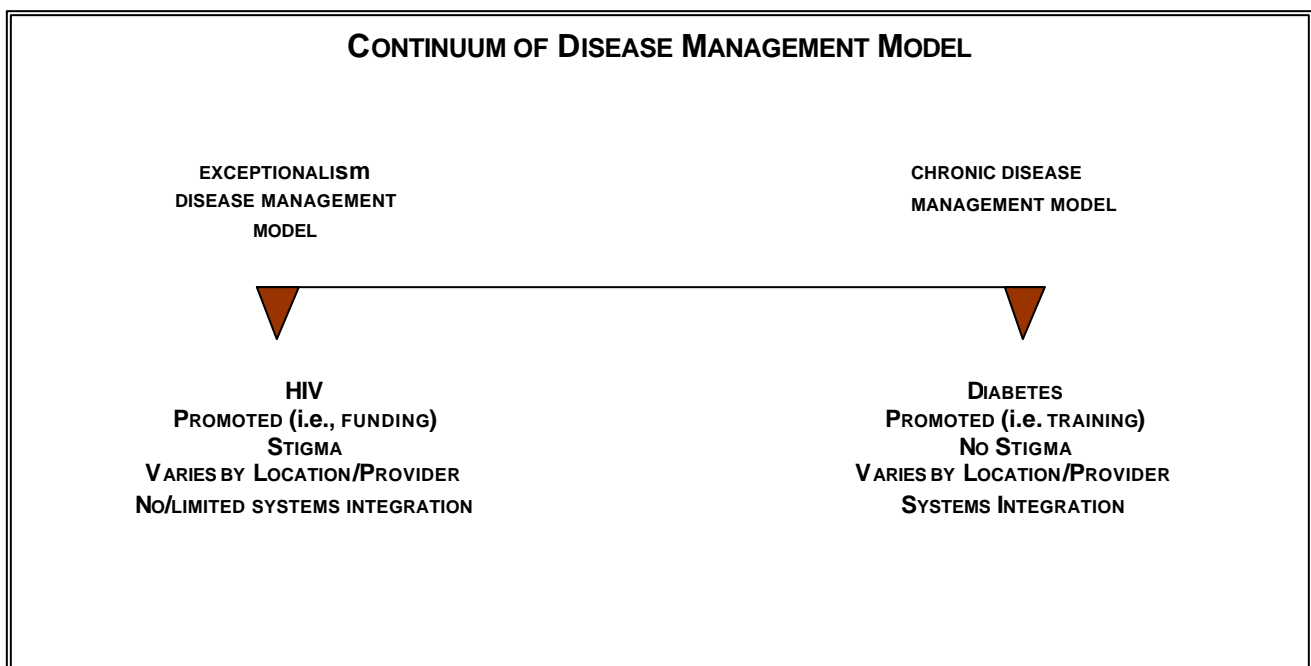
2. Risk/harm reduction is the goal, regardless of HIV status.

Specifically: b. Train providers in the use of computer-based and other risk assessment tools (e.g. ACASI, Regional Medical Library).

3. Promote the prevention of HIV (among those who are HIV+ and HIV-) and other STDs through identification of persons at risk for acquiring HIV/STD infection, training clinicians to perform appropriate screening, patient education, and effective treatment.

Specifically: c. Identify effective technologies that improve capacity to use data for identifying clients at risk for acquiring HIV infection and other STD's.

- d. Identify and train providers to use appropriate telemedicine applications.
4. Recognize the existence of co-factors (mental illness, chemical dependency, homelessness, and sexual abuse among others) in HIV disease. Addressing co-factors requires effective integration of multiple systems to assure access to treatment, and provision of quality prevention, care and treatment services for people at risk for acquiring HIV as well as people living with HIV/AIDS.
- Specifically:
- e. Identify and use current community and social resources.
- f. Unify resources (possibly by establishing a coalition that brings together diverse constituents).
5. Address barriers to mainstreaming care and treatment of HIV disease where and to whatever degree possible. Discussion occurred within context defined by participants as a continuum of disease management models:



- Specifically:
- g. Identify an existing group that can work on addressing barriers (e.g., WSMA, Early Intervention Steering Committee).
- h. Educate health and service providers (e.g., presentation at CAREvent, include as subject area in next Summit).
- i. Actions should be inclusive of other systems to promote and obtain effective systems integration.

j. Identify the model and train providers in use of computer-assisted Chronic Disease Management Models (*develop a model specific to care and treatment of HIV/AIDS*).

6. Fight against homophobia and racism among providers in health care and other service settings especially as it impacts the delivery of quality prevention services, care and treatment. *[Participants recognized Washington State as a leader in developing/implementing new “technologies” to address issues specific to sexual minorities such as domestic partner benefits.]*

Specifically: *Specific recommendations are aimed at eliminating racism, homophobia and other forms of discrimination that surround access to and provision of HIV prevention services, care and treatment. If goal obtained, it is believed that the burden of rights advocates will be lessened, potentially removed.*

k. Move beyond rhetoric and education to action-based approaches that obtain inclusion, anti-discrimination policies, and broader implementation of domestic partner benefits.

l. Develop leadership in addressing racism and homophobia (given absence of in “public health” settings) and issues specific to sexual minorities.

m. Include specific anti-discrimination/inclusion wording in contracts with providers; implement consequences for lack of compliance to be nondiscriminatory and inclusive (i.e., loss of funding).

7. Encourage and support people with HIV infection or any other form of infectious disease to take responsibility for not transmitting the infection to others; this may or may not include disclosure of disease status under certain circumstances (undefined).

*[Evaluator Comments: Participants agreed that this is a value statement, based on social norms, and that it is okay to say a particular behavior is ‘wrong’. However, any discussion must keep in mind that value statements are based on perceived social norms, which differ across racial, ethnic, cultural, community, and other population groups. Consequently, serious and lengthy discussion is required before implementation, taking into consideration primary and secondary consequences of open and honest discussion of HIV status, especially for example between HIV+ clients and employers. Fairness and justness are primary characteristics of a safe environment for dialogue. Although creating such an environment might well be an ultimate goal among care and service providers, it is difficult to imagine its universal creation given its ostensible absence in the particular.]*

Specifically: n. Find ways to get people to talk openly and honestly about their HIV status with their providers and others.

- o. Increase providers' comfort in discussing sexual and risk behaviors with clients, and increase their capacity to conduct culturally appropriate sexual and risk behavior assessments.

Controversial and sometimes adversarial discussion also occurred about whether or not to recommend elimination of the law about knowingly transmitting HIV infection. Since track participants were unable to reach agreement about this issue, it cannot be considered as a policy recommendation at this time. However, it is the opinion of the evaluator and the Summit planning committee that such discussion should continue to address the issues raised.

8. Assure that HIV prevention, care and treatment policies are client-centered.

Specifically:

- p. Conduct policy development in a participatory environment that includes clients, clinicians and other providers, AIDS Services Organizations, public health, affected communities (e.g., gay community).
- q. Include clients at every level of systems integration.
- r. Clearly define and identify clients: their needs, where they are in the HIV continuum (see conceptual framework at beginning of document).
- s. Train providers to effectively assess client needs from a client-centered perspective (i.e., based on client self-assessment) on an on-going basis, allowing for changes in care and services, as needs change.
- t. Increase clients' capacity to make knowledgeable decisions in identifying and accessing appropriate care and services.
- u. Assess need from client perspective and observed behaviors over time, allowing for provision of less, or withdrawal of support/resources if client purposively chooses not to participate.
- v. Permit case managers to reopen a "closed case" based on clients' reassessment of care and service needs.

9. Acknowledge and exert political will to obtain stated recommendations that emerged here and from HIV Policy Summit in general.

Specifically:

- w. Policy Summit leadership to commit to supporting and advocating for obtainment of recommendations.
- x. Washington State Department of Health to provide leadership in obtaining and implementing recommendations.

## APPENDIX G

### TRACK 4 RECOMMENDATIONS

Recommendations presented included only those that received a 2/3 majority approval.

Goal: Reduce morbidity and mortality and prevent new infections.

1. Accountability:

*[Conflict of interest issues arose but there was insufficient time to address these. Group discussion led to discovery of wide variation across regions in the roles, responsibilities, and actions of AIDSNet Coordinators.]*

- a. In order to receive AIDSNet dollars, AIDSNet Coordinators must meet a minimum set of standards, defined by the State.

2. Decision-making:

- b. DOH [Washington State Department of Health] shall standardize the prioritization and allocation process statewide, which includes standards for *parity, inclusion, and representation* (PIR).

3. Structural Change:

- c. Establish a statewide pool *[staying away from use of “set aside” terminology]* from omnibus funds to address hard to reach, cross-geographical groups, as well as those issues selected by regions, in order to establish need (e.g., tribes, corrections, migrant workers).
- d. DOH and AIDSnets shall meet to discuss the development of cross-regional collaborations, if appropriate.
- e. AIDSnets may centralize Omnibus funds within regions based on prevalence.

4. Maximizing Resources:

- f. DOH shall standardize or provide technical assistance regarding the RFP [Request for Proposal] process.
- g. Reduce administrative demand by synchronizing fiscal years where feasible.
- h. Visit the omnibus mandates to look for opportunities to free-up funds to address new and on-going issues. *[In general, areas outside Omnibus were not discussed. Looked at Act as it is now and discussed topics such as Testing and counseling, Technologies, Geography.]*